MINUTES OF THE BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES, STATE OF CALIFORNIA

Violet Varona-Lukens, Executive Officer
Clerk of the Board of Supervisors
383 Kenneth Hahn Hall of Administration
Los Angeles, California 90012

At its meeting held August 24, 2004, the Board took the following action:

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At the suggestion of Supervisor Antonovich and on motion of Supervisor Molina, seconded by Supervisor Burke, unanimously carried (Supervisor Antonovich being absent), the Board set September 14, 2004 at 10:30 a.m. for the Chief of Operations of Public Health, the Director of Maternal, Child and Adolescent Health Programs, and the Area Health Officer of Service Planning Areas 1 and 2, to provide the status on implementing the attached June 2004 report, *Infant Mortality Among African-Americans in the Antelope Valley;* and a status report by the Program Director and Program Sponsor of the Black Infant Health Program, a community-based agency in the Antelope Valley, regarding the above referenced report.

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Attachment

Copies distributed:
Each Supervisor
Chief Administrative Officer
County Counsel
Director of Health Services
Director of Public Health
Chief of Operations, Public Health,
Department of Health Services

THOMAS L. GARTHWAITE, M.D.
Director and Chief Medical Officer

FRED LEAF
Chief Operating Officer

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa Street, Los Angeles, CA 90012
(213) 240-8101

June 23, 2004

TO: Each Supervisor

FROM: Thomas L. Garthwaite, M.D.
Director and Chief Medical Officer

Jonathan E. Fielding, M.D., M.P.H.
Director of Public Health and Health Officer

SUBJECT: **INFANT MORTALITY AMONG AFRICAN AMERICANS IN THE ANTELOPE VALLEY**

On April 13, 2004, the Board approved a motion by Supervisor Antonovich instructing the Director of Health Services to convene a working group of Public Health staff and community agencies to address the alarming rate of infant mortality among African Americans in the Antelope Valley. The working group was charged with a review of the infant deaths, assessment of resources available to improve prenatal care, and the development of recommendations to the Board within 60 days.

Attached is the report which outlines the findings of the working group, and puts forth a series of recommendations to address infant mortality in the Antelope Valley.

If you have questions or require additional information, please let me know.

TLG:JEF:lm
404:011

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Public Health

Infant Mortality in the Antelope Valley
Report to the Board of Supervisors
June 2004

Prepared By:

Deborah Davenport, R.N, M.S.
Area Health Officer
Service Planning Areas 1& 2

Cynthia Harding, M.P.H.
Director
Maternal, Child and Adolescent Health Programs

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EXECUTIVE SUMMARY

This report was prepared in response to the alarming rate of infant mortality among African Americans in the Antelope Valley in 2002. The Los Angeles County Department of Health Services (DHS) recently issued the publication "Key Indicators of Health by Service Planning Area," which demonstrated a rate of 28.4 infant deaths per 1,000 live births for African Americans in the Antelope Valley compared to 11.4 infant deaths per 1,000 live births for African Americans in the County overall, and 5.4 infant deaths per 1,000 live births for all ethnicities in the County.

This report examines local demographic and health related issues, provides a description of the problem, and explores the factors that impact infant death. Several limitations in the data preclude making any conclusions regarding the association between infant death and maternal risk behaviors. The increase in infant deaths in the Antelope Valley is due to an increase in the deaths among African American infants. Further research is required to make any conclusions as to the reasons for these excess deaths.

A community based approach was utilized to develop solutions to the problem of infant mortality and in the Antelope Valley. Three public meetings were held to review data, risk and potential causal factors, and discuss initial recommendations. Five recommendations are presented in this report, along with specific actions that can be taken within existing resources, and actions that will require additional funding. The five recommendations are:

RECOMMENDATION 1: Increase capacity and target access to high risk family support programs for African American women and their families.

RECOMMENDATION 2: Decrease barriers to accessing care by increasing the number of women and infants that have medical insurance.

RECOMMENDATION 3: Collaborate with and educate local health care providers to ensure quality care for African American women and their infants.

RECOMMENDATION 4: Conduct an education and outreach/marketing campaign aimed at African American women and the local community regarding healthy life practices.

RECOMMENDATION 5: Conduct research to determine the causes of infant mortality in the Antelope Valley.

INTRODUCTION

This report was prepared in response to the alarming rate of infant mortality among African Americans in the Antelope Valley. In 2002, the infant death rate in the Antelope Valley was 10.6 per 1,000 live births, a rate significantly higher than the Los Angeles County rate of 5.4 per 1,000 live births. In addition, the infant death rate among African Americans in the Antelope Valley was 28.4 per 1,000 live births, more than five times higher than the overall rate in the County for all ethnicities. In response, the Board of Supervisors instructed the Director of Health Services to convene a working group to address this serious problem. This report includes the working group's analysis and recommendations.

BACKGROUND

National and California State Perspective

The issue of overcoming broad health disparities among racial and ethnic groups in the United States has become a primary focus of health improvement efforts at the federal government level, as well as within the private health advocacy community. In 2000, the U.S. Department of Health and Human Services issued a report on Racial and Ethnic Disparities in Health that included a report from its Workgroup on Infant Mortality. This report outlines the basic and underlying causes of fetal and infant deaths and suggests a multilayered approach to reduce mortality rates as they relate to minority populations in the United States.[1] Chronic or underlying poor health conditions predispose women to problem pregnancies and poor birth outcomes. Among African Americans, issues of diabetes, obesity and hypertension are documented to be at disproportionate levels in the population. Research on the issue of poor birth outcomes, including prematurity and low birth weight, indicates that poor or compromised health at the time of conception and during the gestational period are at the root of the problem. Many states have also examined and are implementing strategies to address this issue.

In California, the state Department of Health Services has several programs that fund work with at-risk populations to assure good birth outcomes and protect the health of the mother and her infant. Available funding from state resources is limited and thus does not allow these programs to supply capacity at the level needed in our communities.

Local Demographics and Health Related Issues

General Population Demographics: To understand the scope of the problem in the Antelope Valley, it is important to highlight key demographics of the region and what impact the region itself has on the issue. The Antelope Valley is approximately 2200 sq. miles and encompasses the northeast region of Los Angeles County and the southeast region of Kern County. One of the area's cities, Palmdale, is one of the fastest growing cities in the state. The latest population estimate in the Los Angeles County portion of the region, referred to as Service Planning Area (SPA) 1, is approximately 341,000, with African Americans comprising about 14% of the total population, Hispanics/Latinos comprising 31%, Caucasians comprising approximately 48%, and the remainder made up of Asian, Pacific Islander, and Native American residents.[2] This population has increased by 32% from 1990 to 2003.

The median age of the population in the Antelope Valley in 2000 was 31.2 years, compared to 32 years for Los Angeles County[3]. Many new, young families are moving into the area because of the

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[1] Racial and Ethnic Disparities in Infant Mortality. Sept. 2000: Workgroup on Infant Mortality, U.S. HHS.
[2] U.S. Census Bureau, 2003 GAVEA Economic Roundtable Report.
[3] United Way, SPA Fact Book, 2000.

availability of middle income housing. Nearly 31% of the workforce in the Antelope Valley typically travels to the San Fernando Valley and Los Angeles for employment, necessitating 3-4 hours of commuting time each day.[4] Families moving into this community usually must seek new health care providers, including prenatal care, causing a disruption in continuity of care.

Access to Health Care: The 2003 Los Angeles County Health Survey indicates that approximately 82% of adults in the Antelope Valley have health care coverage and 92% of children have coverage. Approximately 16% have incomes below the federal poverty level, compared to 17% overall in Los Angeles County.

Health care in the region is provided by several major health care organizations, including Kaiser Permanente, High Desert Medical Groups, Tarzana Treatment Centers, Sierra Medical Group, a number of independent providers, and High Desert Medical Systems (operated by LA County; formerly High Desert Hospital). Hospital services are provided by the Antelope Valley Hospital (an elected hospital district board) and Lancaster Community Hospital (private). A third hospital is in the planning/development phase to be located in the West Palmdale area in 2007/8. Obstetric services in the Valley are available at the Antelope Valley Hospital and also include outpatient prenatal service clinics in East Palmdale. Antelope Valley Hospital also provides a neonatal intensive care unit for this region. While access to urgent care has expanded with the opening of the South Valley Urgent Care Center (L.A. County High Desert Medical Systems) and the Kaiser Urgent Care site, both in East Palmdale, the emergency rooms at the Antelope Valley Hospital and Lancaster Community Hospital continue to experience severe overcrowding and very high demand for service.

General Health Status: According to the "Key Indicators of Health" report issued by Los Angeles County Public Health in 2003, the Antelope Valley has some of the highest rates in the county for tobacco products use (20.6%), adult overweight (39%), adult and child asthma (12% and 10% respectively), hypertension (22%), breast cancer death rate (24.2 /100,000 population), lung cancer death rate (52.6/100,000 population), and coronary heart death rate (225.2/100,000 population).[5]

In Los Angeles County, African Americans are disproportionately affected by certain chronic conditions, which is significant to the Antelope Valley because of the large African American population. For example, African Americans in Los Angeles County have the highest percentage of adults with diabetes (9%), the highest rate of asthma among adults (10%) and children (16%), and the highest proportion of low birth weight infants (12%).

Health Planning: Aside from the cities of Lancaster and Palmdale, the Antelope Valley is sparsely populated with fewer than 250 people per square mile. The region is recognized by the state of California as "rural" for purposes of state health planning. However, the federal government recently reclassified the Antelope Valley as "urban" along with many other remote communities in California due to a new methodology derived from the RUCA methodology used by USDA. This methodology theorizes that accessing employment in more distant and larger urban areas signals better access to health care providers and, therefore, makes those communities ineligible for direct federal health care dollars targeted for rural areas. This policy is being heavily debated with HHS throughout California and the other states impacted by this decision.

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[4] State of California Employment Development Department, July 2003; 2003 Antelope Valley Labor Base Analysis; Claritas, Inc. December 2002; 2003 GAVEA Economic Roundtable Report.

[5] Key Indicators of Health by Service Planning Area. 2003: Los Angeles County Department of Health Services, Public Health, Office of Health Assessment and Epidemiology.

While the area has its own transportation agency as part of the Metropolitan Transit Authority, transportation around the valley is limited and geared for transporting most riders out of the area in the morning to work and returning in the evening. Midday transportation needed to access health care appointments is limited.

DESCRIPTION OF THE PROBLEM

Los Angeles County's infant death rates declined throughout the 1990s reaching the lowest rate in 2000 (see Tables 1 and 1A). Since 2000, the infant death rate in the County has increased from 4.9 infant deaths per 1,000 live births in 1999 to 5.5 in 2002, a 12.2% increase. Data for 2003 is not yet available. In 2001, the infant death rate in Los Angeles County (5.4 per 1,000 live births) was comparable to the State of California (5.3 per 1,000 live births)[6] and lower than the United States (6.8 per 1,000 live births.)[7] However, within Los Angeles County, as in other areas, there remained geographical and racial/ethnic disparities. The infant death rate for African Americans is significantly higher than for all other races, at a rate of 13.1 per 1,000 live births in 2002 compared to the County rate of 5.5 per 1,000 live births. Additionally, the rate differs by SPA, with Antelope Valley having a significantly higher rate than other SPAs.

Although Antelope Valley represented 6% of the infant deaths reported in 2002, the infant death rate has surpassed other SPAs, experiencing an increase of 112% between 1999 and 2002, compared to the rest of Los Angeles County which remained relatively stable. The SPA 1 infant death rate rose from 5.0 in 1999 to 10.6 deaths per 1,000 live births (35 and 52 deaths, respectively). See Figures 1 and 2, and Tables 2 and 2A.

African Americans have had the highest infant death rate in Los Angeles County. In 2002 the African American infant death rate was 13.1 per 1,000 live births, which was more than two times higher the rate for whites in LAC (5.2 deaths per 1,000 live births). This trend is also true in the Antelope Valley. The infant death rate for African Americans in the Antelope Valley increased from 11.0 (7 cases) in 1999 to 32.7 (27 cases) in 2002, while other races only had slight increases. Whites had the lowest infant death rate of 5.5 followed by Hispanics (6.6) in 2002. In fact, the observed increase in infant death rate in the Antelope Valley is entirely attributed to the increase in infant deaths among African Americans. Figure 3 illustrates this fact, as the trend curve for the Antelope Valley infant death rate mirrors the trend among African Americans, yet is different from the trend among other races.

[6] California Department of Health Services, Center for Health Statistics, Vital Statistics

[7] Centers for Disease Control and Prevention, National Center for Health Statistics System: "Deaths: Final data for 2001," NVSR Volume 52, No. 3. 116 (PHS) 2003-1120

Table 1: Infant Deaths
Los Angeles County, California, & US 1998 to 2002

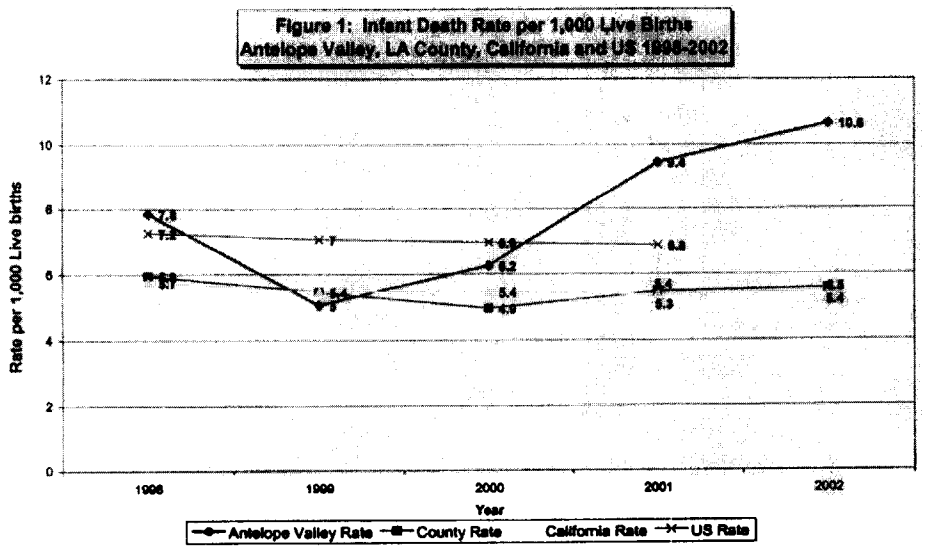
Race/Ethnicity	1998	1999	2000	2001	2002
County Total	936	841	777	828	825
Asian/Pacific Islander	67	56	38	57	63
American Indian	0	2	0	0	0
African American	193	144	172	145	157
Hispanic	515	485	430	491	459
White (Non-Hispanic)	157	153	133	132	144
Other/Unknown	4	1	4	3	2
California Total	2,994	2,787	2,884	2,815	N/A
U.S. Total	28,325	27,864	27,960	27,568	N/A

Table 1A: Infant Death Rate per 1,000 Live Births
Los Angeles County, California, & US 1998 to 2002

Race/Ethnicity	1998	1999	2000	2001	2002
County Rate	5.9	5.4	4.9	5.4	5.5
Asian/Pacific Islander	4.5	3.7	2.3	3.7	4.0
American Indian	n/a	n/a	n/a	n/a	n/a
African American	13.5	10.5	12.8	11.4	13.1
Hispanic	5.3	5.0	4.4	5.1	4.8
White (Non-Hispanic)	5.1	5.2	4.6	4.7	5.2
Other/Unknown	n/a	n/a	n/a	n/a	n/a
California Rate	5.7	5.4	5.4	5.3	5.4
U.S. Rate	7.2	7	6.9	6.8	N/A

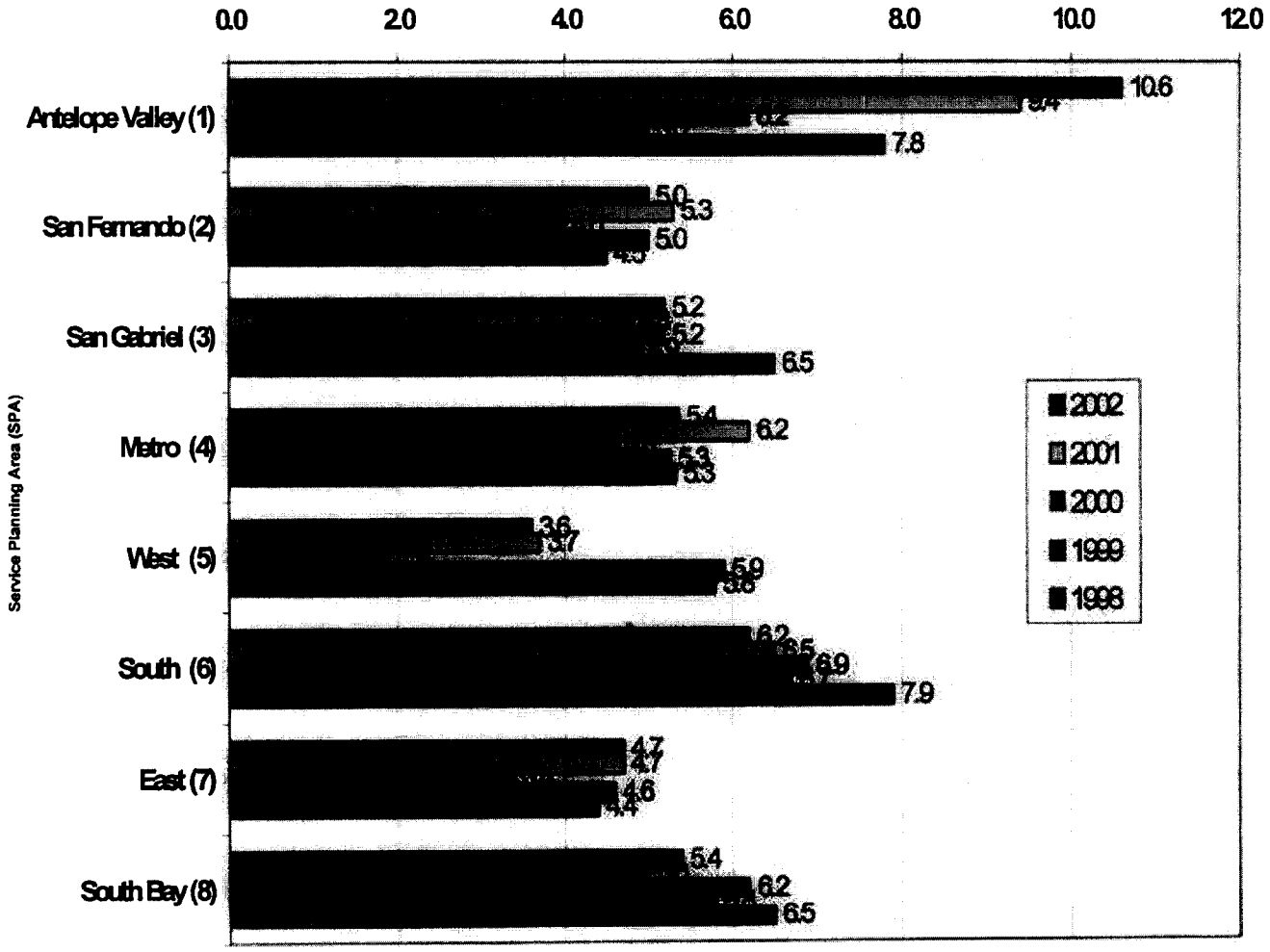
n/a = Rate not calculated if fewer than 5 deaths

Source: California Department of Health Services, Center for Health Statistics, Vital Statistics, 1998 to 2002
Centers for Disease Control and prevention, National Center for Health Statistics, Infant Mortality Statistics 1998-2001; Linked Birth/Death Data Set



Note: National data for 2002 not available.
Source: California Department of Health Services, Center for Health Statistics, Vital Statistics, 1998 to 2002
Centers for Disease Control and Prevention, National Center for health Statistics System, Infant Mortality Statistics from the 1998- 2001 Period. Linked Birth/Death Data Set

Figure 2: Infant Death Rate per 1,000 Live Births by SPA
Los Angeles County, 1998 to 2002



Source: California Department of Health Services, Center for Health Statistics, Vital Statistics, 1998 to 2002

Table 2: Infant Death by Race/Ethnicity in Antelope Valley, Los Angeles County, 1998 to 2002

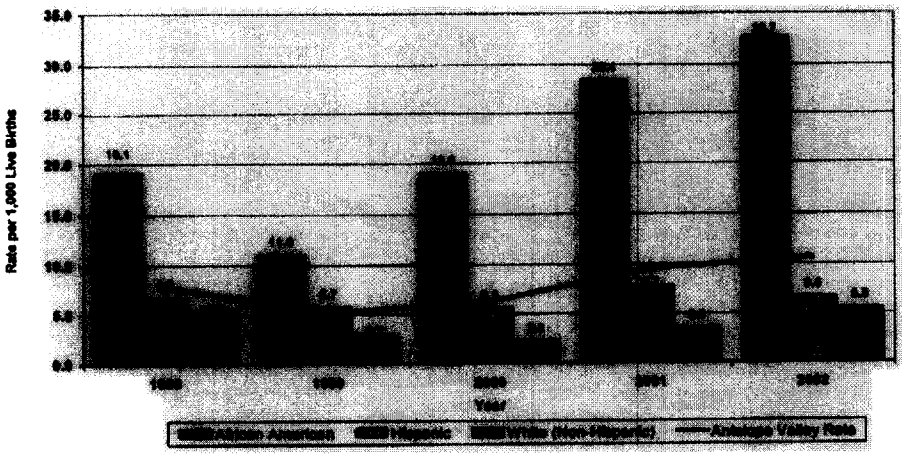
Asian/Pacific Islander	1	0	0	0	1
American Indian	0	0	0	0	0
African American	12	7	14	22	27
Hispanic	12	10	11	15	15
White (Non-Hispanic)	10	5	4	6	9
Other/Unknown	0	0	0	0	0

Table 2A: Infant Death Rate per 1,000 Live Births by Race/Ethnicity in Antelope Valley, Los Angeles County, 1998 to 2002

Asian/Pacific Islander	n/a	n/a	n/a	n/a	n/a
American Indian	n/a	n/a	n/a	n/a	n/a
African American	19.1	11.0	19.0	28.4	32.7
Hispanic	6.7	5.7	5.6	7.7	6.6
White (Non-Hispanic)	5.2	2.7	n/a	3.5	5.5
Other/Unknown	n/a	n/a	n/a	n/a	n/a

n/a = Rate not calculated if fewer than 5 deaths
Source: California Department of Health Services, Center for Health Statistics, Vital Statistics, 1998 to 2002

Figure 3: Infant Death Rate per 1,000 Live Births by Race/Ethnicity in Antelope Valley Los Angeles County, 1998 to 2002



Source: California Department of Health Services, Center for Health Statistics, Vital Statistics, 1998 to 2002

Factors That Impact Infant Death

The causes of infant death are both multifactorial and complex. Studies suggest that some of the potential risk factors associated with infant death include: prematurity and disorders related to short gestation; low birth weight; congenital anomalies; young maternal age; low maternal education level; substance abuse; poor maternal nutrition; inadequate prenatal care; unintended pregnancy; maternal psychosocial problems; existing medical conditions during pregnancy and delivery; pregnancy complications; short interpregnancy interval; injury (including domestic violence); infection; respiratory distress syndrome; and a lack of breastfeeding.

A preliminary look at the 2002 death data in the Antelope Valley, showed that of the 52 infant deaths, 37 (71%) occurred in infants during the neonatal period (less than 28 days old), and 15 (29%) occurred in infants during the post-neonatal period (28-364 days old). Data from the death certificate provide limited answers. The preliminary analysis of the neonatal deaths indicates that maternal health, birth trauma, low birthweight or extreme prematurity, and fatal congenital conditions were factors. Of the older infants, respiratory disorders including pneumonia and SIDS were prevalent. The current data do not allow us to make any conclusions regarding the association between maternal risk behaviors, demographics (e.g. teen mothers) and the increase in infant deaths, and point to a need to conduct further research.

Reporting Delay

The finalized infant death data is released with a two year delay. This report reviews the data from 2002. DHS will not have the final infant death count for 2003 for Los Angeles County until March 2005. This significant lag in the data makes it difficult to determine any unusual trends in a timely manner.

COMMUNITY-BASED APPROACH TO ADDRESS INFANT MORTALITY

In response to the Board of Supervisors' motion on April 13, 2004, the Department of Health Services (DHS), Public Health, conducted three public meetings to review data, risk and potential causal factors, and make initial recommendations for this report. Meetings were held on April 23, 2004; May 21, 2004; and June 3, 2004, and included participants from a wide array of agencies (see Attachment I).

RECOMMENDATIONS

The recommendations in this report include strategies that are derived from evidence-based research on reducing infant mortality and community-validated approaches that have proven effective in reaching and connecting with African American women, their infants and families. The community collaborative understands that this is a multi-year project that requires the commitment of Los Angeles County and its health and human service departments, local city governments, local health and social service agencies, voluntary agencies, the faith community, and the business and resident community of Antelope Valley to reduce African American infant mortality in this area.

There are five recommendations which can be implemented immediately, utilizing in-kind resources and existing staff. There are several actions within these recommendations that will require seeking grant funds to implement specific programs. Recommendation 5 will require the allocation of additional staff and resources. DHS will request funding to implement the proposed actions in Recommendation 5 through the MCAH state grant for fiscal year 2004-05.

Recommendation 1
Increase capacity and target access to high risk family support programs for African American women and their families.

Rationale: Community-based strategies which focus on comprehensive case management and access to services, have proven immensely effective in increasing utilization of services, improving satisfaction with prenatal care, and improving birth outcomes.[8] Current resources exist in the Antelope Valley to connect pregnant women, children and families to needed services, but many of them are at capacity and, without additional funding, will not be able to enroll additional clients or provide more services. The programs listed below have demonstrated effectiveness in improving the lives of African American women, children and their families.

- The role of the Black Infant Health (BIH) Program of the Antelope Valley is to eliminate the disproportionate African American infant mortality and low birth weight and to improve related health status indicators in the Antelope Valley African American communities.
  The program is funded through a contract with the DHS MCAH Programs. The subcontractor is the Partners In Care - First Missionary Baptist Church.[9] The program has been in place since January 2002 and has conducted community-based perinatal outreach education and public

[8] Perinatal Health Systems Initiatives in Local Communities, Report from the Women's and Children's Health Policy Center, Johns Hopkins University, 2003.
[9] Subcontract will change as of July 1, 2004 to the Public Health Foundation Enterprises, Inc. – First Missionary Baptist Church.

awareness campaigns, followed by the provision of services and care coordination to African American women in the community, both pre- and post-natal, following children up to the age of two. The project provides prenatal outreach to clients through community events, presentations, street outreach and other methods, and enrolls clients in the Social Support and Empowerment model interventions, which are eight-week, two-hour classes that provide at-risk pregnant and parenting African American women with social support and life-skills enhancement. The current contract funds 2 community outreach workers and a caseload of 74 women.

- DHS contracts with Tarzana Treatment Center to provide outreach and enrollment assistance for health coverage programs in the Antelope Valley. Tarzana conducts their outreach in community-based sites, including schools, community health fairs, swap meets, and others. They provide comprehensive screening and enrollment assistance, looking at the full range of low and no-cost health coverage programs to determine for which programs family members qualify. In addition to assisting families with enrolling in health insurance programs, Tarzana conducts follow up to ensure that applications were submitted and approved, and to encourage families to use their health benefits by taking their children to the doctor for preventive care. Tarzana also follows up at the time of annual re-determination, to assist families in retaining their health benefits over time.

- The Nurse-Family Partnership (NFP) Program uses a national, well-researched nurse home visitation model for first-time pregnant young (teen) mothers who are living in poverty. The Dr. David Olds "Prenatal and Early Childhood Nurse Home Visitation" model is used to guide the public health nurses in home visitation services throughout the County. The goals of the NFP Program are to foster healthier pregnancies, improve the health and development of children, and promote family self-sufficiency. The local and nationwide data has proven the success of this intervention modality on all cultural groups served within Los Angeles and nationwide. There are two NFP public health nurses working within the Antelope Valley, and current capacity would only allow three new clients to be enrolled at this time.

- The Prenatal Care Guidance (PCG) Program is a nurse home visitation program that uses Public Health Nurses (PHNs) to provide nurse home visitation services to women in Los Angeles County who are experiencing high-risk pregnancies, and includes women with previous children. Women can enroll into the program at any time during their pregnancy and up to ten weeks postpartum. Nurses provide home visits until the baby is 12 months of age. During the visits, the nurses provide assistance with enrollment into health coverage programs; counseling and education regarding prenatal care, parenting skills, breastfeeding issues, dangers of smoking and substance use during pregnancy, labor and delivery issues, infant development; and referrals to other programs as needed. The objectives of the program are to increase care coordination and follow-up to assure timely access to prenatal care, increase enrollment in Medi-Cal and other coverage programs, enhance access to other community resources, and ensure positive birth outcomes. Currently, there are 240 clients enrolled in the program, and a computerized data system has just been implemented to track program outcomes over time. There are currently two PCG public health nurses working within the Antelope Valley, and both are at full capacity with 30+ clients each.

- Title X funds are used for targeted outreach and partnering with community based organizations to provide family planning services in the Antelope Valley. Currently DHS-MCAH administers the Title X dollars for the Antelope Valley Health Center. DHS submitted

a proposal for re-authorization of Title X funds, including a request for an augmentation for the Antelope Valley. If funded, starting January 2005, the Antelope Valley Health Center would set-up a partnering agreement with the Antelope Valley BIH program to conduct outreach to African Americans for family planning services.

- Healthy Homes is a credentialed program that is part of the Healthy Families America/Prevent Child Abuse America model. It is a home visitation program that operates solely within the Antelope Valley, based at the Antelope Valley Hospital, and assists at-risk and high-risk families during pregnancy or at birth to create and sustain safe, healthy and nurturing homes. It has the capacity to serve 85-125 families with newborns each year (based on turnover), and has served 514 families since operations began in 1998. The Healthy Homes Program has been shown to reduce child abuse and strengthen family functioning. Unfortunately, this vital and effective family support program will cease operations at the end of January 2005, due to a lack of funding.

As seen by the above examples, there are resources for pregnant women, children and families in the Antelope Valley, however, many are at capacity, and others are at risk of losing funding and disappearing. In addition, a geographical analysis of the current health care resources mapped against the target populations demonstrated that most of the services are not located where high risk clients live. This issue, when coupled with the limited transportation services in the Antelope Valley, points to a need to develop women's care services local to where it is determined that at-risk women and their infants reside.

Actions:

- **By August 2004, organize a resource group of local provider groups and community advocates to determine the viability of opening a women's health care local one-stop-shop or "drop-in" care center for at-risk women in targeted areas of the Antelope Valley. Features could include but not be limited to:**
  - Traveling clinic/ storefront service
  - No appointment needed
  - Include resources that address pre-conception care, nutrition, chronic disease prevention, pre-natal care resources, stress reduction, parenting techniques, pregnancy peer groups and education regarding high-risk life-styles (e.g., alcohol and drug use) and care techniques (e.g., bottle-propping, infants placed on their stomach to sleep, soft bedding, etc.) that could impact infant mortality.
  - Pattern the "drop-in" care clinics after successful Family Resource Centers that utilize the "Principles of Family Support Practice" (see Attachment II) established by the Children's Planning Council and adopted by the Board of Supervisors.
  - Network with existing providers to link women to needed resources.
  - ***Budget impact:*** The Area Health Officer will use current staff resources to work with the provider groups to determine feasibility and fundraising strategies.

- **By August 2004, Area Health Office and local community health collaborative will submit at least one application for additional funding to increase the capacity of programs that target at-risk African American women and teens. Examples include but are not limited to the following:**
  - Grant applications to augment community-based contract programs such as Black Infant Health

- MCAH nurse home visitation Program Administrator will work with the Area Health Officer and the Director of Healthy Homes to investigate options for continued funding to sustain program operations and develop a continuum of home visitation services for high-risk, African American families within the Antelope Valley;
- Expansion of the Public Health Nurse-Family Partnership and Prenatal Care Guidance Programs in the area in collaboration with the community-based, Healthy Homes Program in order to establish a continuum of care services that could continue to provide in-home support services for the target population.
- Investigate potential funding (e.g., grants, TCM/MAA, etc.) to support continuance of the community-based Healthy Homes organization within the Antelope Valley.
- ***Budget Impact:*** No new financial cost as grant writing will be done by Area Health Office and MCAH in collaboration with staff from Antelope Valley community based organizations.

Recommendation 2
Decrease barriers to accessing care by increasing the number of women and infants that have medical insurance.

Rationale: Although women needing prenatal care are "presumptively qualified" to receive Medi-Cal through the gestation, delivery and immediate postpartum period, this coverage ends after the birth of the baby. According to the Northeast Florida Healthy Start Coalition's Project Impact report, a Fetal and Infant Mortality Review (FIMR) case review identified general health of the mother as the most frequently identified contributing factor in the fetal and infant death cases they reviewed, appearing as a factor in 73% of cases. Medical conditions included pre-pregnancy chronic conditions such as diabetes, hypertension, and related conditions. Providing health coverage beyond the pregnancy period would provide women with access to medical care to manage chronic conditions, as well as access to inter-conception care and family planning. In addition, providing pre-conception care, by targeting women of reproductive age for preventive treatment and care of chronic conditions before they get pregnant, can reduce poor birth outcomes.

Infants born to women on Medi-Cal are eligible for ongoing Medi-Cal for one year. However, a newborn referral form must be submitted to ensure that the child is transferred from the mother's case (which will expire) to the child's own case so that benefits can be maintained for the full year. Forms are given to birth hospitals, but are not always completed.

Actions:

- **By September 2004, SPA 1 Area Health Officer, MCAH Director and members of the Los Angeles Best Babies Collaborative (LABBC), will work with Los Angeles County legislative analysts to prepare language to advocate for Medi-Cal coverage for women two years post-partum to provide inter-conception care.**
  - ***Budget Impact:*** The impact of improving the general health of at-risk women has been demonstrated to decrease health care costs related to high risk conditions that are attenuated or prevented altogether that can then act as precursors to poor birth outcomes. AHO, MCAH and LABBC will provide in-kind staff resources to develop the legislative analyses.

- **By September 2004, the SPA 1 Area Health Office will work with community partners and health care providers to increase the use of the newborn referral form for infants born to mothers on Medi-Cal.** This recommendation would be for birth hospitals to develop a system to automatically complete and submit the newborn referral forms, and to work with DPSS to develop a feedback mechanism so that hospitals can submit forms in batches and receive information back that the forms have been received.
    - ***Budget Impact:*** The AHO will utilize current staffing resources to coordinate and produce a planning and feasibility report that will include projected costs.

Recommendation 3

Collaborate with and educate local health care providers to ensure quality care for African American women and their infants.

Rationale: The Comprehensive Perinatal Services Program (CPSP) was created in 1984 to reduce the morbidity and mortality among low income pregnant women and their infants. It was implemented statewide as a fee-for-service Medi-Cal benefit in 1987. CPSP was based on a pilot project in which health education, nutrition, and psychosocial services, case coordination, and prenatal vitamins were provided to approximately 7,000 low income women over a three year period. When birth outcomes were compared with those women who had received standard prenatal care, low birthweight rates were reduced by one-third for those women who received comprehensive care. In addition, for every dollar spent on the program, an average of two dollars was saved in short-term neonatal intensive care unit costs alone.

Based on the program's proven record of improved birth outcomes and cost savings, CPSP was included as a benefit for all pregnant Medi-Cal managed care (MMC) enrollees when the two-plan model for MMC was instituted in Los Angeles County in1997. All MMC contracting health plans are required to ensure that their pregnant members have access to CPSP services.

Currently, four obstetrical providers in SPA 1 are CPSP certified; however, only 3 are providing services. Given the high infant mortality rate in SPA 1 compared to the rest of Los Angeles County, all Medi-Cal eligible pregnant women need access to comprehensive perinatal services. This will require the support of all obstetrical providers and managed care health plans in SPA 1. In order to accomplish this, resources will need to be identified for the provision of assessments, perinatal education, and high risk medical, psychosocial, nutritional and health education referrals.

Another important focus of activity in working with the provider community is facilitating and encouraging mothers to breastfeed. In Los Angeles County, African American mothers have the lowest prevalence of breastfeeding initiation (63%), with only 27% of that group completing 6 months of breastfeeding and only 14% completing 12 months or more.[10] Breastfeeding improves maternal health, minimizes postpartum bleeding and facilitates bonding between infant and mother. Breastfed infants have fewer infections, allergies, chronic diseases, and certain cancers. It is also associated with decreased obesity and adult-onset diabetes. Therefore, any efforts to decrease infant morbidity and mortality must include provider education about the benefits of breastfeeding as well as encouragement and support for mothers who want to breastfeed their infants.

[10] L.A. Health Briefs: Breastfeeding Practices. March 2004: Los Angeles County Department of Health Services, Public Health, Office of Health Assessment and Epidemiology.

Sudden Infant Death Syndrome (SIDS) is the leading cause of death among infants beyond the neonatal period. The "Back To Sleep" campaign was launched in 1994, when sleeping in the prone position (stomach) was identified as a risk factor for SIDS. Since then, the rate of SIDS has decreased dramatically in the U.S. and in Los Angeles County. However, SIDS rates are three times higher among African Americans both locally and nationally[11]. In addition to sleeping position, other risk factors for SIDS include exposure to maternal smoking during pregnancy, and environmental tobacco smoke in the home. Providers should instruct parents to place infants to sleep on their backs and educate patients about reducing smoking during pregnancy and around infants in the home.

Actions:

By July 2004 DHS Public Health will initiate an educational program to educate providers regarding infant mortality data, causes of poor outcomes and strategies to assure and improve quality of care. Components of the educational program will include but not be limited to:

- Infant mortality data
- Strategies for clinical management and treatment compliance
- Cultural sensitivity / awareness education
- SIDS awareness and prevention strategies
- ***Budget Impact:*** No new financial impact, in-kind services from Area Health Office and MCAH.

By the end of FY 2004-2005 DHS prenatal clinics will provide CPSP-level of care as part of Departmental goals to assure quality of care and integration of Public Health into Personal Health services.

- ***Budget Impact:*** No new financial impact, in-kind services from Area Health Office and MCAH.

By December 2004 provide at least two educational sessions to promote CPSP and prenatal care guidelines for use by community health providers to enhance psychosocial outreach and resource referral to women enrolled in Medi-Cal for their prenatal care.

- ***Budget Impact:*** No new financial impact, in-kind services from Area Health Office and MCAH.

- **By December 2004 SPA 1 Area Health Office and MCAH to provide information and provider education regarding the role of breastfeeding in preventing infant mortality and the advantages to becoming a Baby-Friendly Hospital, hiring lactation consultants, and promoting breastfeeding in hospital programs.**
  - ***Budget Impact:*** No new financial impact, in-kind services from Area Health Office and MCAH.

- **By December 2004, Nurse-Family Partnership, Prenatal Care Guidance, Black Infant Health and the other Antelope Valley community-based home visitation programs will train a portion of their home visiting staff as Certified Lactation Educators who will be available to assist their clients with breastfeeding issues.**

[11] L.A. Health Briefs: April 2002: Infant Sleep Position and Sudden Infant Death Syndrome (SIDS) in Los Angeles County, Public Health, Office of Health Assessment and Epidemiology.

- ***Budget Impact:*** Funding for training will come from the State MCH grant. Other activities will be carried out through in kind services from Area Health Office and MCAH.

Recommendation 4

Conduct an education and outreach/marketing campaign aimed at African American women and the local community regarding healthy life practices.

Rationale: The community workgroup agreed that a large-scale marketing effort to African American women and their families would have a positive impact on infant mortality by encouraging early entry into prenatal care, healthy lifestyle/ habits for weight control and nutrition, preventive screening for hypertension, diabetes, and women's health care, as well as the need for pediatric preventive checkups and nutrition. This campaign would also include information on how to access care and where to receive assistance for referral to high-risk maternal and child health programs, parenting classes, counseling, smoking and other substance abuse cessation programs and classes.

- **By July 2004 Antelope Valley Partners for Health and the Area Health Office will update the community resource guide and collaborate with First 5 Connect to increase use of local services by African American families.**
  - ***Budget Impact:*** No new financial impact, in-kind services from Area Health Office and MCAH. Antelope Valley Partners for Health has completed the initial revision and the AHO will facilitate collaboration with First 5 Connect on ways to let local African American families to know about these resources and the guide.

- **By July 2004, SPA 1 AHO to work with the CAO Service Integration Branch to make available the Most Commonly Required Documents (MCRD) to increase knowledge regarding processes and information needed to obtain Medi-Cal, CalWORKs, and other benefits for high-risk families.**
  - ***Budget Impact:*** No new financial impact, in-kind services from Area Health Office and MCAH.

- **By August 2004, the Area Health Office and community collaborative will study the feasibility and plan for a community-based family mentoring program that utilizes local agencies as support systems for targeted high risk families.**
  - This program would be primarily a voluntary program utilizing programs such as the Black Infant Health Program as a referral point for women seeking emotional support and empowerment.
  - ***Budget Impact:*** The AHO will utilize current staffing resources to collaborate with community partners to determine the feasibility, costs and funding strategies for this mentoring program.

- **By August 2004, MCAH and the Area Health Office will conduct at least three community focus groups to gain further insight into community-identified issues and strategies that focus on infant mortality.**
  - ***Budget Impact:*** No new financial impact, in-kind services from Area Health Office and MCAH.

By September 2004 the Area Health Office will create a speaker's bureau to conduct outreach to increase community awareness and highlight the benefits of early prenatal care, breastfeeding, and the importance of "preconception care".

- ***Budget Impact:*** No new financial impact, in-kind services from Area Health Office and MCAH.

By September 2004, the Area Health Office will collaborate with local health care agencies and businesses to provide training on Baby-friendly facilities and services for employers.

- ***Budget Impact:*** The Area Health Office and MCAH will utilize current staffing and resources to develop the program and seek grant-funded sources to provide this training. Estimated cost of program development is $25,000.

- **By November 2004 the Area Health Office will collaborate work with the Breastfeeding Task Force of Greater Los Angeles's Breastfeeding Works Program to promote workplace lactation accommodation in the Antelope Valley.** This program provides support to employers who wish to provide a lactation program for their breastfeeding employees.
  - ***Budget Impact:*** The Area Health Office will utilize current staffing and resources to develop the program in collaboration with the Task Force and seek grant-funded sources to provide this training. Estimated cost of program development and employer training is $25,000.

- **By December 2004, Area Health Office will publish a resource guide for community and provider distribution that reviews issues such as Medi-Cal enrollment for both mothers and their infants, family support programs such as parenting and mental health counseling, as well as resources for assistance with alcohol and drug abuse issues in families.**
  - ***Budget Impact:*** No new financial impact, in-kind services from Area Health Office, MCAH, and website support services from Office of Health Assessment and Epidemiology.

Recommendation 5
Conduct research to determine the causes of infant mortality in the Antelope Valley.

Rationale: To understand why infant mortality has increased in the Antelope Valley, it is necessary to determine the causes of birth outcomes known to contribute to infant mortality. Historically, the finalized infant death data is released by the State DHS several years after the death occurred, which prevents LAC from detecting any unusual trend of infant deaths in LA County in a timely manner. In addition, data on the death certificates is limited. A review of the medical charts, supplemented by client interviews is required to gain an understanding of the risk factors and other issues surrounding the infant death. In addition, to prevent future infant death, more information is needed on maternal risk behaviors, quality of prenatal care, and satisfaction with care.

Actions:

- **By August 2004, SPA 1 Area Health Office will set up a Community Advisory Board to review research outlined above and to make recommendations about implementation in the Antelope Valley.**

- ***Budget Impact:*** DHS will carry out this work with current funding and staff, with coordination of community board work shared by MCAH and the SPA 1 Area Health Office.

- **By September 2004, DHS MCAH in collaboration with the SPA 1 Area Health Office will conduct a retrospective study of 2002 infant deaths in the SPA 1 to identify risk factors that may be associated with adverse birth outcomes, utilizing a Fetal Infant Mortality Review (FIMR) process.**
  The National Fetal Infant Mortality Review (FIMR) Project protocol will be adapted to perform case reviews of the 52 infant deaths in SPA 1 in 2002. The project involves reviewing and abstracting data from the hospital and health provider medical charts, coroner reports, and public health nursing reports when available. We will also attempt to locate and interview the parents or caretakers. The 52 case reviews should allow us to highlight areas where interventions may be initiated to reduce infant mortality in the SPA 1 communities. Possible areas for improvement may include pre- and inter-conception care, prenatal and high-risk obstetrical care, neonatal medical management, infant pediatric care, and health education.
  - ***Budget Impact:*** No new financial impact, in-kind services from Area Health Office, MCAH, UCLA Center for Healthier Children, Families and Communities, the Los Angeles Best Babies Collaborative, and the Regional Perinatal Advisory Council for Los Angeles County (PAC/LAC).

  By September 2004, DHS MCAH will conduct the Los Angeles Mommy and Baby (LAMB) Project with a representative sample of all live births in SPA 1 to identify factors associated with adverse birth outcomes. The Maternal, Child, and Adolescent Health Programs will undertake a study that will provide information on the adverse birth outcomes, low birth weight and pre-term birth. Birth record and survey data will be gathered on factors known to affect birth outcomes. Areas to be examined include: access to care; adequacy, utilization, and content of prenatal care; physical and emotional abuse; mental health; maternal health and pregnancy history; and environmental factors. The recommended study would select 640 women from the Antelope Valley. The sample would be chosen to ensure that the women are representative of newly delivered mothers in the Antelope Valley.
  - ***Budget Impact:*** MCAH has applied for a grant from HRSA to implement the LAMB Project countywide, and should know about the results of this proposal in August 2004. If the LAMB Project is funded, it will provide for sufficient resources to carry out this activity countywide. MCAH will focus implementation in the Antelope Valley in the first phase of this project.

  By October 2004, DHS MCAH will set up a fetal-infant mortality expanded surveillance system (FIMESS) to monitor fetal-infant mortality in Los Angeles County in a timely fashion. In collaboration with the Office of Health Assessment and Epidemiology, we will create a database system, FIMESS, to capture all infant and fetal deaths that occurred in LA County, without having to wait for the State DHS final infant death file. This will allow us to monitor unusual trends and base programmatic directions on current data.
  - ***Budget Impact:*** Attachment III contains a proposed budget to carry out these activities. Funding has been requested as part of the state MCAH grant for fiscal year 2004-05.

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Antelope Valley Better Babies Coalition
Antelope Valley Hope Foundation
Antelope Valley Hospital
Antelope Valley Hospital WIC Program
Antelope Valley Life Foundation
AV Christian Center
Black Infant Health (BIH) Program of Antelope Valley
Children's Bureau
El Nido
First Missionary Baptist Church of Little Rock
Grace Missionary Church
Healthy Homes of Antelope Valley Hospital
High Desert Medical Group
Antelope Valley Partners for Health
Kaiser Permanente
L.A. County Dept. of Mental Health
L.A. County DHS Alcohol and Drug Programs Administration
L.A. County DHS Children's Medical Services
    California Children's Services
    Child Health and Disability Prevention (CHDP)
L.A. County DHS High Desert Medical Systems
L.A. County DHS Immunization Program
L.A. County DHS Maternal Child and Adolescent Health (MCAH) Program
    Child Health Initiatives Unit
    Maternal Health and Family Planning Administration
    Research, Evaluation and Planning Unit
    Comprehensive Perinatal Services Program
    Nurse Family Partnership
    Prenatal Guidance Program
L.A. County DHS Office of AIDS Programs and Policies (OAPP)
L.A. County DHS Office of Health Assessment and Epidemiology
L.A. County DHS Public Health, Medical Officer
L.A. County DHS Service Planning Area 1 - Area Health Office
L.A. County DHS Sexually Transmitted Disease Program
L.A. County DHS Tobacco Control Program
L.A. County DHS Office of Women's Health
Los Angeles Better Babies Coalition
PACLAC
Tarzana Treatment Centers
The Church of Jesus Christ World Changers
United Christian Fellowship

PRINCIPLES OF FAMILY SUPPORT PRACTICE

The **Principles of Family Support Practice (Principles for Partnership)** were developed to create the foundation for County-community partnerships based on mutual respect and accountability. These principles will serve as a benchmark for how the County's health and human services system, and its community partners, will interact and work with families and communities in their efforts to achieve the five Board approved outcomes for children and families: Good Health, Economic Well-Being, Safety and Survival, Social and Emotional Well-Being and Education and Workforce Readiness.

The following **Principles of Family Support Practice** will now guide the delivery of health and human services to children and families in Los Angeles County:

- Staff and families work together in relationships based on equality and respect.
- Staff enhances a family's capacity to support the growth and development of all family members, adults, youth, and children.
- Families are resources to their own members, to other families, to programs, and to other communities.
- Programs affirm and strengthen a family's cultural, racial, and linguistic identities, and enhance their ability to function in a multicultural society.
- Programs are embedded in their communities and contribute to the community building process.
- Programs advocate with families for services and systems that are fair, responsive, and accountable to the families served.
- Practitioners work with families to mobilize formal and informal resources to support family development.
- Programs are flexible and continually responsive to emerging family and community issues.
- Principles of Family Support Practice are molded in all program activities, including planning, governance, and administration.

County departments and their community partners will integrate these statements of best practices into their ongoing work, and in the design of any initiatives intended to improve outcomes for children and families. Through the adoption of these principles, the health and human services delivery system will evolve in ways that build the capacity of families and communities to meet their own needs; not just giving them fish, but helping them to learn to fish.